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Florida v. HHS - Amicus Brief of Doctors4PatientCare et al.

Doctors4PatientCare

No. 11-11021

IN THE

United States Court of Appeals

FOR THE ELEVENTH CIRCUIT

STATE OF FLORIDA, et al.,

Plaintiffs-Appellees,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants-Appellants,

On Appeal from the United States District Court
for the Northern District of Florida (No. 3:10-91 (RV))

BRIEF OF *AMICI CURIAE* DOCS4PATIENTCARE, THE BENJAMIN RUSH SOCIETY, AND THE PACIFIC RESEARCH INSTITUTE IN SUPPORT OF PLAINTIFFS-APPELLEES

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CORPORATE DISCLOSURE STATEMENT AND CERTIFICATE OF INTERESTED PERSONS

Amicus Curiae Docs4PatientCare is a nonprofit 501(c)(6) membership organization of doctors. *Amicus Curiae* Benjamin Rush Society is an unincorporated nonprofit membership group of medical students, doctors, and others that was organized by, is administered by, and is part of the Pacific Research Institute (PRI). PRI is a nonprofit 501(c)(3) organization dedicated to promoting free markets.

None of the above entities is publicly traded or has any parent corporations, and no publicly traded corporation owns 10% or more or any of the above entities.

Pursuant to 11th Cir. R. 26.1-1, the undersigned counsel certifies that, in addition to the persons and entities listed in the briefs for the parties and *amici curiae* that have previously been filed with this court, the following persons and entities may have an interest in the outcome of this case, and that, to the best of his knowledge, the list of persons and entities in the party and *amici* briefs already filed is otherwise complete:

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Dated: May 11, 2011

/s/ Erik S. Jaffe
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INTEREST OF *AMICI CURIAE*

Amicus Curiae Docs4PatientCare is a nonprofit 501(c)(3) membership organization of concerned physicians committed to the establishment of a health care system that preserves the sanctity of the doctor-patient relationship, promotes quality of care, supports affordable access to all Americans, and protects patients' freedom of choice. It has an interest in this case because the individual mandate contradicts these fundamental principles and sets a dangerous precedent regarding the inappropriate use of federal power to dictate the choices of Americans.

Amicus Curiae Benjamin Rush Society is a membership organization that includes medical students, residents, fellows, and doctors across the political spectrum — as well as members of the general public — who believe that the profession of medicine calls its practitioners to serve their patients, rather than the government. The Society believes that the physician-patient relationship is a voluntary and mutually beneficial one. Both parties have a right to enter this relationship freely. The proper role of government is to protect this freedom, not to diminish it. The Society is part of the Pacific Research Institute. The Society is interested in this case because the individual mandate undermines such freedom by compelling some individuals to purchase health insurance notwithstanding their free choice to contrary.

The Pacific Research Institute is a nonprofit 501(c)(3) organization that champions freedom, opportunity, and personal responsibility by advancing free-market policy solutions to the issues that impact the daily lives of all Americans. And it demonstrates how free interaction among consumers, businesses, and voluntary associations is more effective than government action at providing the important results we all seek—good schools, quality health care, a clean environment, and economic growth. Founded in 1979 and based in San Francisco, PRI is a non-profit, non-partisan organization supported by private contributions. its activities include publications, public events, media commentary, invited legislative testimony, and community outreach.

This brief is being filed with the consent of all parties.

STATEMENT OF ISSUES

Whether the district court erred in holding that the minimum coverage provision of the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA") is not a valid exercise of Congress's commerce power?

SUMMARY OF ARGUMENT

The individual mandate cannot be constitutionally justified by the federal appellants' claims that it regulates inactivity – the failure to obtain healthcare coverage – that nevertheless has a substantial effect on interstate commerce. While

appellants attempt to misdirect attention with gaudy (and questionable) numbers – 50 million uninsured, $116 billion in annual consumption of healthcare by those uninsured, $43 billion of such care for which providers supposedly are not compensated – even assuming, *arguendo*, such numbers to be true they have little to do with, and are not cured by, the individual mandate. Indeed, the federal government's own analyses confirm that the individual mandate does not address the bulk of the alleged problem of uncompensated care, does not significantly reduce any costs absorbed or passed on by healthcare providers, and what little uncompensated care costs it might reduce does not have a substantial effect on interstate commerce.

Comparing the design and operation of the individual mandate with the nature of the uncompensated care alleged by appellants, there is a nearly complete disconnect (and sometimes a *negative* correlation) between the individual mandate's effect on healthcare coverage and the provision of uncompensated care. The individual mandate at best only causes 16 million persons to obtain coverage they otherwise would forego. A comparison of compensation rates for healthcare consumption by those 16 million persons with and without such coverage shows that the mandate will actually increase uncompensated care by pushing millions of uninsured into Medicaid (which generates a far higher rate of uncompensated care than do the uninsured on their own). And even apart from the effects of increased

Medicaid enrollment, the mandate only even has the *potential* of act upon $1.2 billion in genuinely uncompensated care from those 16 million people.

In the context of the $2.42 trillion in total annual spending for healthcare, the trivial amount of uncompensated care affected by the individual mandate (even using the government's own numbers) amounts to a mere 0.05% of total spending on healthcare and does not substantially affect the prices for healthcare or insurance. Even assuming the alleged problem of uncompensated care in general, therefore, the individual mandate thus does not address that problem, may in fact worsen it, and thus cannot be constitutionally justified based on the utterly insubstantial effects on interstate commerce of the tiny fraction of uncompensated care upon which it potentially operates.

In addition to the factual disconnect between the individual mandate and the uncompensated care alleged to justify it, the government's constitutional theories concerning the effect of uncompensated care suffers a conceptual disconnect in that the bulk of such care is provided pursuant to charitable donation, government funding, or unfunded government coercion. None of those things are *commercial* activities. Charity is unilateral and non-commercial. Government payment for medical care, whether directly through Medicaid or indirectly through grants to hospitals and the like, is a governmental activity, not a commercial one. And government compulsion of genuinely uncompensated care creates costs imposed

by the government itself, not the recipients. The commerce effects of such compulsion cannot be used to bootstrap the government to still further authority under the Commerce Clause.

Finally, the government's overall approach to the role that economic effects play in the application of the Commerce and Necessary and Proper Clauses is flawed in that it considers "economic" effects at too high a level of generality, neglecting the narrower and more particular scope of the constitutional term "commerce." Viewed at the government's level of generality, everything about human existence is essentially economic, and all actions and inactions have an *effect* on the market and hence on commerce. At that level of generality the notion of commerce and the limits of the Commerce Clause, are rendered meaningless.

ARGUMENT

I. APPELLANTS VASTLY OVERSTATE THE RELATIONSHIP BETWEEN THE INDIVIDUAL MANDATE AND THE ISSUE OF UNCOMPENSATED CARE.

The federal appellants claim that 50 million uninsured annually consume $116 billion in healthcare, $43 billion of which is uncompensated, "*i.e.*, care not paid for by the patient or a third party." Appellants Br. at 11 (*citing* 42 U.S.C.A. § 18091(a)(2)(F) and Families USA, *Hidden Health Tax: Americans Pay a Premium*, at 2, 6 (2009)); *see also* Appellants Br. at 2 ("$43 billion in 2008" in uncompensated care shifted to healthcare providers); *id*. at 10 ("approximately 50

million people" had no health insurance in 2009 and consumed "over $100 billion of health care services annually") (*citing* Census Bureau Report, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, at 23, table 8, and Families USA, *Hidden Health Tax*, at 2 ($116 billion in 2008)"). That $43 billion purported cost of uncompensated care is supposedly shifted mostly to insurance companies, resulting in higher premiums for consumers. Appellants Br. at 2. Such shifting of costs into interstate commerce is then cited as a Commerce-Clause justification for the individual mandate, which purportedly will "reduce the uncompensated care obtained by the uninsured and paid for by other participants in the health care market." *Id*. Congress itself offered the similar supposed justification that "that the consumption of health care without insurance has substantial adverse effects on the interstate health care market. 42 U.S.C.A. § 18091(a)(2)(F).

The federal appellants' claim that the individual mandate is needed because 50 million uninsured are shifting $43 billion in uncompensated-care costs, however, is misleading and grossly overstated. Whatever effect *other* provisions in the Act may have on uncompensated care – a separate and separately contentious question – the individual mandate itself is unrelated to any significant impact from uncompensated care on the healthcare market.

As the federal government itself has recognized, the Act in its entirety will not result in universal insurance and will leave a substantial number of persons uninsured. According to Congressional Budget Office ("CBO") projections, by 2019, the Act as a whole will only generate coverage for 60% of an otherwise projected 55 million uninsured, with the individual mandate accounting for coverage of only 16 million persons. CBO, *Analysis of the Major Health Care Legislation Enacted in March 2010*, at 18 (March 30, 2011), *available at* http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf (Table 3 showing estimates of coverage with and without the Act and a total reduction of only 33 million of the projected uninsured); CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, at 2 (June 16, 2010), *available at* http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf ("eliminating the individual mandate … would increase the number of uninsured by about 16 million people").

In seeking to determine whether the *individual mandate* is justified by the supposed shifting of uncompensated care costs claimed to have a substantial effect on interstate commerce, it is only the uncompensated care targeted and affected by the individual mandate that should be relevant to the Commerce Clause analysis. The pertinent question, therefore, is the cost of uncompensated care that would

exist *but for* the mandate itself. Translated back to the 2008 cost figures for uncompensated care, the amount actually at issue when considering the individual mandate is, *at most*, based on 32% of the 2008 pool of unemployed, or $13.8 billion (32% of $43 billion in total costs of uncompensated care) in uncompensated care that might exist – and hence potentially provide the Commerce-Clause justification – absent the mandate.[1]

Even that $13.8 billion is a substantial exaggeration of the purported effect on commerce from costs of uncompensated care supposedly targeted by the mandate. The reason the figure is exaggerated is that the individual mandate does not eliminate the costs of uncompensated care even among those persons it causes to get coverage. In fact, many of the persons affected by the mandate will receive as much or more uncompensated care even after they obtain coverage, will

[1] Because consumption and uncompensated care are based on the 2008 figures of 50 million uninsured, we use that as the denominator when determining the relative consumption and uncompensated costs for the 16 million whose behavior changes due to the mandate. For ease of calculation we have conservatively assumed that the per-person costs of uncompensated care are equally distributed among the uninsured. However, as discussed below, *infra* at 13-15, that assumption likely overestimates the effect of the individual mandate on the amount of uncompensated care received by those whose behavior will be changed by the mandate. Many of the 16 million uninsured pressed by the mandate into obtaining private or employer-based coverage likely consume less healthcare than the average uninsured, and likely paid out of pocket a higher than average percentage of their healthcare costs while uninsured. Those persons thus consumed less than their pro-rata share of uncompensated care, and removing them from the pool of the uninsured will have a smaller impact in reducing uncompensated care.

consume more care than they would without coverage, will themselves pay less for such services, and will require governments and third parties to pay far higher total costs than if they were uninsured.

To see how the mandate does not even address much of the problem purported to justify it under the Commerce Clause, it is necessary to examine the *type* of coverage the 16 million added insureds will obtain as a result of the mandate. The CBO conveniently provides a breakdown: of the 16 million persons who would be uninsured but for the mandate, the mandate will cause 4-5 million persons to obtain employer-sponsored coverage, 5 million persons to obtain individual coverage (including through the insurance exchanges created by other parts of the Act), and 6-7 million to obtain governmental coverage under Medicaid and the Children's Health Insurance Program (CHIP). CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, at 2. Of particular interest is the 6-7 million persons who will be channeled into governmental coverage. For those persons, the individual mandate will not substantially reduce the cost of uncompensated care because such coverage simultaneously increases their consumption of healthcare services yet systematically under-compensates providers for such services. The result is that those persons shifted into Medicaid as a result of the mandate will continue to receive as much or more uncompensated care as they did when they were uninsured

It is well recognized that the uninsured consume approximately 50% less healthcare than do the insured.[2] Once covered by government programs – under which they would pay little or nothing for healthcare – the newly covered can be expected to double their consumption.[3] While such consumption will now be covered under Medicaid and CHIP, it is also well recognized that Medicaid

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[2] Peter Harbage & Len M. Nichols, *A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System*, ISSUE BRIEF # 3, at 2 (New America Foundation Dec. 2006), available at http://www.newamerica.net/files/HealthIBNo3.pdf (uninsured receive less than 40% of the care received by the insured in California and nationally receive an average of 50% of the care received by the insured) (citing for the national figure Agency for Healthcare Research and Quality, *Research Findings #27: Health Care Expenses in the United States, 2000* (April 2004), *available at* http://www.meps.ahrq.gov/data_files/publications/rf21/rf21.shtml.); Jack Hadley & John Holahan, *How Much Medical Care Do the Uninsured Use and Who Pays for It?*" 2003, HEALTH AFFAIRS, at W3-69 to W3-70, available at http://content.healthaffairs.org/content/early/2003/02/12/hlthaff.w3.66.full.pdf (full year uninsured received about half as much care as the privately insured).

[3] Much of the differential consumption is attributable to lack of access to and resources for health care, particularly for low-income uninsured. For higher income uninsured, however, those choosing to forego insurance are, on average healthier, though the 50% consumption differential between insured and uninsured holds even controlling for health. Jack Hadley, John Holahan, Teresa Coughlin & Dawn Miller, *Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage*, at 19 (Kaiser Commission on Medicaid and the Uninsured, August 2008), available at http://www.kff.org/uninsured/upload/7809.pdf ("the uninsured use less care than the insured (holding health status constant), because they pay for much of their care themselves and because their health is generally better than the insured's"). Persons who would receive governmental insurance under the mandate, however, fall into the former group, with consumption likely a function of resources and having to internalize much of the cost of care. Once they are

systematically underpays for healthcare services, on average paying only 72% of the amounts paid by Medicare, which itself pays only 80% of what is paid by private insurers.[4] That amounts to Medicaid paying, on average, only 57.6% of private payers – a 42% underpayment. Appellant HHS itself, however, places Medicaid payments at only 70% of private health insurance, a 30% underpayment.[5] That 30% to 42% underpayment for services provided to those brought into Medicaid as a result of the individual mandate represents as much or more uncompensated care as the 37% underpayment by the uninsured asserted by the

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under governmental coverage for which they do not have to pay, their consumption of healthcare that is now entirely free to them will rise.

[4] David Olmos, Mayo Clinic in Arizona to Stop Treating Some Medicare patients, Bloomburg, December 31 2009, ("Nationwide, doctors made about 20 percent less for treating Medicare patients than they did caring for privately insured patients in 2007, a payment gap that has remained stable during the last decade"), *available at* http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aHoYSI84VdL0; Stephen Zuckerman, Aimee F. Williams & Karen E. Stockley, *Trends in Medicaid Physician Fees 2003-2008* , Health Affairs, April 28, 2009, at w510 (Medicaid fees were only 72% of Medicare fees in 2008), *available at* http://content.healthaffairs.org/content/28/3/w510.full.html; Colorado Children's Healthcare Access Program, *Compare: Reimbursement for Medicaid Versus Commercial Health Insurance Versus Office Expenses*, CCHAP Newsletter Three – Article 1, January 2007, at 2 (reimbursement rates for pediatric care routinely less than half of commercial rates and rarely above 80% of commercial rates), available at http://www.cchap.org/newsletter-three/#one.

[5] John D. Shatto & M. Kent Clemens, Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers, Office of the Actuary, Centers for Medicare and Medicaid Services, HHS, August 5, 2010, at 5 (Figure 1) (Chart Showing Medicaid Payments 30% below private health insurance), available at http://www.cms.gov/ActuarialStudies/Downloads/2010TRAlternativeScenario.pdf.

government. *See* Federal Appellants Br. at 10-11 (uninsured consume $116 billion in healthcare services in 2008; $43 billion in uninsured healthcare services uncompensated).[6]

Combining these numbers yields quite startling results that are wholly at odds with appellants' claimed constitutional justifications for the individual mandate. Assuming a midrange CBO figure of 6.5 million people as the number of uninsured that will obtain government coverage as a result of the individual mandate, an average annual healthcare consumption rate for the uninsured of $2320 per person (based on appellants' own figures of $116 billion annual consumption divided by 50 million persons), and an average underpayment rate of 37% for the uninsured (again based on appellants' own numbers), those 6.5 million people would consume roughly $5.6 billion worth of uncompensated care if they were uninsured. Once driven into governmental coverage by the individual mandate, however, their per-person consumption will double to $4640 annually and the underpayment rate will range from 30% to 42% resulting in their consumption of *$9.0 billion to $12.7 billion* worth of uncompensated care. Thus, while the mandate will certainly provide those persons with more care, it actually

[6] The undercompensation rate for the uninsured according to the numbers in the federal appellants' brief is thus $43 billion divided by $116 billion, or 37%.

increases the amount of uncompensated care they receive and the costs that are potentially shifted. In medical terms the purported cure is worse than the disease.

Returning to our analysis of the amount of uncompensated care addressed by the individual mandate, therefore, the uninsured whose behavior will be influenced by the mandate consume at best $13.8 billion in uncompensated care. But those shifted into government coverage would continue to consume $9 billion to $12.7 in uncompensated care even after the mandate due to the consumption incentives and underpayment of the government programs. The potential net effect of the individual mandate on the problem of uncompensated care is now down to, *at best*, a net $4.8 billion reduction in such costs – a far cry from the $43 billion effect on commerce claimed by appellants. And using the higher estimate of 42% undercompensation by Medicaid, the individual mandate would only net a $1.1 billion reduction in the cost of uncompensated care.

Even the best-case scenario of a $4.8 billion reduction in uncompensated care from the uninsured influenced by the mandate continues to be too high. As many have noted, and as the federal government in fact counts upon, those uninsured persons who will be pressed by the mandate into buying private insurance are in fact healthier on average and, by definition, wealthier than those eligible for government insurance. They are thus unlikely to consume as much

healthcare when uninsured and are capable of themselves paying for a bigger portion of the healthcare that they do consume while uninsured.

An analysis of the relevant data by other *amici* in this case notes that persons subject to the mandate – the young, healthy, and uninsured annually consume, on average, only $854 per person in healthcare rather than the government's figure of $2320 per person. *See* Brief for *Amici Curiae* American Action Forum and Economists in Support of Appellees/Cross Appellants and Affirmance, May 11, 2011, at 13-14 & App. A. Even continuing to assume that 37% of that amount is uncompensated care – far less likely at such lower consumption or among uninsured not poor enough to be eligible for Medicaid – those persons account for only $316 per person in uncompensated care for a total of $2 billion annually.

Going back to our earlier estimates of $13.8 billion as the amount of uncompensated care attributable to those whose behavior would be changed by the mandate, recall that $5.6 billion was attributable to the low-income subgroup that would obtain Medicaid, leaving $8.2 billion in uncompensated care attributed to the non-Medicaid-eligible subclass under the government's usage numbers. But if this subgroup is indeed healthier and wealthier than average, consumes less than average, and hence is responsible for only $2 billion ($6.2 billion less than the earlier estimate), then the total pre-mandate uncompensated care for the 16 million

the mandate will influence is only $7.6 billion, and that becomes the upper limit of the mandate's *potential* savings. Given that shifting the poorer sub-group affected by the mandate to Medicaid will continue to generate at least $9 billion in uncompensated care, even under the more conservative estimate of Medicaid underpayment, the mandate would on balance *increase* uncompensated by $1.4 billion. And if the undercompensation from Medicaid is at the higher end of the range, the mandate would actually increase the cost of uncompensated care by $5.1 billion.[7]

Finally, it is worth noting that what appellants have described as $43 billion in uncompensated care is not in fact all *uncompensated*; at least not from the perspectives of hospitals. Even the source relied upon by appellants, Families USA, recognizes that at least $14 billion or 33% of that amount is paid for by government grants. Families USA, *Hidden Health Tax*, at 32 (Appendix Table 1).

[7] Even assuming that *all* 16 million of the uninsured influenced by the mandate consumed healthcare at the lower rate of $854 per person annually, that would mean that the group affected by the mandate consumed $13.5 billion in total healthcare only $5.1 billion of which was uncompensated when they were uninsured, holding the rate of non-compensation the same. (16 million x $854 x 0.37 = $5.056 billion.) The group that would go to Medicaid then would account for $5.6 billion in total consumption and $2.1 billion in uncompensated care. Shifting to Medicaid would double their total consumption to $11.2 billion, for which Medicaid would undercompensate providers by from 30% to 42%, leading to uncompensated care of $3.4 to $4.7 billion. Backing that amount out of the potential $5.1 billion reduction in uncompensated care leaves between $1.7 billion

Thus, at least 33% of the cost of uncompensated care discussed so far is not absorbed by private providers or passed on to insurance companies, but rather is paid by the government, no different than the care provided by Medicaid. Such amounts are not properly included in the costs of uncompensated care supposedly borne and passed on by healthcare providers thereby affecting interstate commerce.

A more recent study, however, noted that the Families USA figure overlooked numerous sources of government funding for otherwise uncompensated care and concluded that governments, rather than hospitals, actually pay for 75% of otherwise uncompensated care. Hadley, *et al.*, *Covering the Uninsured in 2008*, at 50 ("government payments account for about 75% of the costs of uncompensated care"); *id.* at 51 (discussing numbers from Families USA and describing sources of government funds not included in their uncompensated care figures); *see also* Harbage & Nichols, *A Premium Price*, at 3 ("as much as 85 percent of the costs incurred on behalf of the uninsured and underinsured are paid for by a combination of governmental subsidy programs").[8] That reduces the

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and $0.4 billion as the potential net impact of the mandate in reducing the cost of uncompensated care.

[8] We have not thus far discussed the costs of government payments for uncompensated care to the uninsured because appellants' Commerce Clause theory has turned on the notion that it is the shifting of costs to private providers and insurers that exerts the requisite effect on interstate commerce necessary to invoke the Commerce and Necessary and Proper Clauses. But to the extent that the government funds care for the uninsured subject to the individual mandate, suffice

amount of uncompensated care costs borne by private providers and supposedly affecting commerce by 75%. Such government payments reduce the amount of genuinely uncompensated care from $4.8 billion, *supra* at 13, to $1.2 billion. That number would then be swamped by the increase in uncompensated care costs due to the mandate's shift of 6.5 million people into Medicaid. Those former uninsured would generate from $9 to $12.7 billion in uncompensated consumption, 75% of which would presumably still be offset by indirect government payments, thus resulting in $2.3 to $3.2 billion in genuinely uncompensated care and hence a net *increase* in uncompensated care from the mandate of $1.1 to $2.0 billion.

What all the preceding analysis amply demonstrates is that uncompensated care to the uninsured, and any supposed cost shifting that results therefrom, is an issue that has little or nothing to do with the individual mandate, is not significantly cured and may in fact be exacerbated by the individual mandate, and that even using the government's own questionable numbers and conservative assumptions, the amount of genuinely uncompensated care that might be addressed by the mandate is at most $1.2 billion annually. And that potential reduction

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it to say that the mandate, even with its penalty provisions, does not ameliorate such costs but in fact exacerbates them. As the CBO has recognized, the individual mandate will impose a net cost to the federal government of $252 billion dollars between 2014, when it becomes effective, and 2020. CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, at 1-2. Such

would be more than offset by the increase in uncompensated care from shifting 6.5 million people onto Medicaid.

Aside from the offsetting increase from pushing more people into Medicaid, however, even the bare $1.2 billion of relevant uncompensated care pre-mandate is trivial in the context of national spending on healthcare of $2.4 trillion dollars, It amounts to an inconsequential 0.05% of spending and certainly does not have a substantial effect on interstate commerce. In fact, it is effectively a rounding error. Rather than the individual mandate being a means of addressing $43 billion in uncompensated care and supposed cost shifting that significantly affects commerce, it at best addresses a miniscule amount of costs that are unlikely to be noticed, much less shifted, in the context of interstate commerce in healthcare. At worst, the mandate actually causes more uncompensated care than it purports to address. Nothing in such circumstances supports an invocation of the Commerce and Necessary and Proper Clauses based on the effects on interstate commerce of the uninsured covered by the mandate.

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costs overwhelmingly exceed any amounts the government may currently pay toward uncompensated care for those who are subject to the mandate.

II. APPELLANTS MISCHARACTERIZE THE RELATIONSHIP BETWEEN UNCOMPENSATED CARE AND "COMMERCE."

Even apart from the lack of any *substantial* connection between the actual conduct affected by the individual mandate and the problem of uncompensated care, the relationship between any such healthcare and "commerce" is likewise far more attenuated than the federal appellants suggest. As the federal appellants readily acknowledge, much of the reason people receive uncompensated care in times of need is because "[f]or decades, state and federal laws have required emergency rooms to stabilize any patient who arrives with an emergency condition, regardless of whether the person has insurance or otherwise can pay." Appellants Br. at 8; *see also id*. at 35-36. Even apart from such requirements, private doctors and hospitals would and do provide care to those without the means to pay out of humanitarian and charitable impulses. Providing essential services without regard to financial means is, of course, laudable, just as providing food, clothing, and housing to the poor and homeless likewise reflects the compassion and generosity of so many in our society. But such praiseworthy activity is best characterized as *charity*, not commerce. Conflating the two strips away the well-established line between economic and non-economic activities, reflected in the Constitution's delimiting use of the word "commerce" itself, Supreme Court case law, tax code provisions regarding nonprofits and charitable deductions, and common sense. *See, e.g.*, *United States* v. *Lopez*, 514 U.S. 549 (1995)

(distinguishing commercial and non-commercial activities, even where the latter may have an effect on commerce); 501(c) corporations and deductions for charitable donations.

The fact that many persons pay for the same services via a commercial transaction – whether through an insurance policy or out-of pocket – or can pay for some, though not all, of the services they receive, does not render the mere act of *giving* such services without compensation a commercial transaction. Such giving lacks the bilateral nature of commerce properly understood, and is a unilateral response to a need, rather than an exchange.

That such charitable giving of services may often be mandated by government edict or longstanding tort principles – and hence not always charity in the strict sense of a voluntary gift – does not alter this basic reasoning or render such giving commerce. "Uncompensated" care funded by charitable donations to hospitals, clinics, and the voluntary donation of time by private doctors remains charitable, regardless whether further duties also compel such care. And "uncompensated" care funded by government grants and subsidies likewise

remains charitable rather than commercial – it is merely the government that is choosing to provide such charitable resources.[9]

That private charities or the government choose to fund or compel care for those who cannot afford it may well have economic effects on the market, but it is not itself commerce and does not shift *costs* to other participants in the commercial market. Rather, those costs are born by those electing to give charity or by the government via taxing and spending. But an effect on charitable decisions or governmental spending decisions is not an effect – substantial or otherwise – on commerce. It is an effect on non-commercial categories of activity that does not readily fit within the category of "commerce."

Finally, to the extent that the government *compels* providers to provide uncompensated medical services they would not otherwise provide, the costs of those services are not being imposed or shifted by the recipients, but rather by the government itself. In that instance it is the *government* that is imposing costs and potentially affecting commerce, not the underlying recipients of such services.

[9] Even if government spending on healthcare for those who cannot pay for it is not deemed charity, it would still not be commercial, but rather governmental in nature, no different from numerous types of government aid and even Medicaid itself. Government spending must be viewed as something different than private commerce insofar as it is subject to the different constitutional authority for the government to tax and spend for the general welfare, and conflating it with private commerce would collapse much of the distinction between those two sources of and limits on federal power.

Attributing those costs to the recipients of government-coerced care, and then claiming Commerce-Clause authority to preemptively regulate all potential future recipients of coerced care a result, is disingenuous bootstrapping. The cause of any economic distortion is the government itself. The federal government cannot expand its own authority by manufacturing the circumstances of uncompensated care and claiming that such circumstances now affect interstate commerce. There is no limit to the Commerce Clause if the federal government can attribute the consequences of its own conduct to citizens who have engaged in no commercial transactions.

III. APPELLANTS PRESENT THE RELATIONSHIP BETWEEN "ECONOMIC" ACTIVITY AND "COMMERCE" AT TOO HIGH A LEVEL OF GENERALITY FOR CONSTITUTIONAL PURPOSES.

Finally, *amici* offer a brief observation on the federal appellants' conflation of broadly conceived economic principles of supply and demand with the necessarily narrower constitutional concept of "commerce." Taken to extremes, *amici* suppose that all attributes of human existence could be described in economic terms in that they create (or fail to create) demand for various goods and services broadly defined. Life necessarily entails both needs and desires – *demand*, at least in the abstract. We need food, water, and shelter to live. We desire numerous goods and services to improve our condition or fulfill our goals – education, companionship, information, entertainment, luxury. Sometimes such

demand is met and sometimes not. Sometimes we supply the demand ourselves or with our family, sometimes others meet the demand. Sometimes we are simply given the things we need or want – by friends, generous strangers, the government – and sometimes we obtain that which we need or want as part of an exchange. Only the latter means of fulfilling our needs and wants can even begin to be considered "commerce" in the constitutional sense of an affirmative transaction involving the *exchange* of goods, services, or money. A unilateral gift of services is not such an exchange and is not commerce. While the federal government may deem such limitations and others to be overly formalistic and claim that all means of meeting demand and even the failure to create demand have effects on the economy, the law must recognize the necessity and propriety of such formalisms.

The Constitution and the Supreme Court have drawn certain distinctions that must be respected, notwithstanding what the government might think. Because the Constitution limits the federal government's power to regulating "commerce," there must be a category of behavior that is not commerce. Because the Supreme Court has distinguished between commercial and non-commercial activities, notwithstanding attenuated upstream or downstream effects on the economy, this Court should likewise do the same. Charity, like many other activities, is not properly deemed a "commercial" activity. Similarly, this Court also should follow the Supreme Court in its consistently limited application of the Commerce power

to the regulation of affirmative *activities*, rather than mere inactivity or the inchoate potential for future activity. Failure to draw such limits on the theory that economic effects transcend all such formalistic boundaries would abandon the very formalities inherent in the written constitution from which government – including the courts – gain their legitimacy. "That way there be dragons."

Under the federal appellants' view, mere existence is inevitably economic in nature and has an effect (positive or negative) on virtually all markets. Regardless whether such a high level of generality in considering markets and economics is plausible as an academic exercise, it is unacceptable as a constitutional theory. By its very words, the Commerce Clause and the case-law surrounding it presuppose and require a much lower level of generality that gives meaning to each of the distinctions described above. If the mere incidents of existence are economic, then everything is economic, everything affects commerce, and the Commerce Clause is an empty shell.

CONCLUSION

For the above reasons, this Court should affirm the decision below insofar as it declares the individual mandate unconstitutional and declines to sever it from the remaining provisions of the Act.

Respectfully Submitted,

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May 11, 2011

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing Brief of Appellants complies with the 7,000 word type-volume limitation of Fed. R. Civ. P. 29(d) and the type-face requirements of Fed. R. Civ. P. 32(a)(5) & (6) in that it uses Times New Roman 14-point type and contains 5707 words, excluding the table of contents, table of authorities, and certificates of counsel. The number of words was determined through the word-count function of Microsoft Word.

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CERTIFICATE OF SERVICE

I hereby certify that, on May 11, 2011, I filed the foregoing Brief for *Amici Curiae* Docs4PatientCare, Benjamin Rush Society, and Pacific Research Institute In Support of Appellees with this Court, by causing a copy to be electronically uploaded and by causing the original and six paper copies to be delivered by UPS. I further certify that, I caused the brief to be served on May 11, 2011, upon the following counsel by electronic mail, and by hard-copy via UPS on the counsel denoted with asterisks:

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